Overview of Health Center Program Requirements

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Health Resources and Services Administration
Bureau of Primary Health Care
Medicare and Medicaid statutes define a provider type: “Federally Qualified Health Center” (FQHC)

- Respectively, Social Security Act §1861(aa)(4) and §1905(l)(2)(B)

- Entity that receives a grant under section 330 of the Public Health Service Act – Health Center Program

- Entity that is determined by HHS to meet requirements to receive funding without actually receiving a grant (i.e., FQHC “Look-Alike” entity – PINs 2009-06 and 2009-07)

- Entities that are outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.
Federal support for health centers began in 1965 under President Johnson’s War on Poverty.

The Health Center Program (authorized under section 330 of the Public Health Service (PHS) Act) includes:

- Community Health Center Program – section 330(e)
- Migrant Health Center Program – section 330(g)
- Health Care for the Homeless Program – section 330(h)
- Public Housing Primary Care Program – section 330(i)

FY 2010 appropriation of $2.190 billion.

HRSA provides Federal grant funding to almost 1,200 health center grantees in every State, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin that deliver primary and preventive care through almost 8,000 comprehensive service sites.
Health Center Program: Fundamental Principles

- Private non-profit or public agency that must serve a high need community or population, i.e. medically underserved areas (MUA) or medically underserved populations (MUP);
- Governed by a community board of which a majority (at least 51%) are health center patients who represent the population served;
- Provide comprehensive primary care services as well as enabling/supportive services such as education, translation and transportation that promote access to health care;
- Services are available to all with fees adjusted based on ability to pay;
- Establish linkages and collaborative arrangements with other community providers to maximize resources and efficiencies;
- Meet other performance and accountability requirements regarding administrative, clinical, and financial operations.
• Access to Federal grant funds to support the costs of uncompensated care

• Eligible for –
  – Enhanced reimbursement under Prospective Payment System (PPS) or other state-approved alternative payment methodology for services provided under Medicaid
  – Cost-based reimbursement for services provided under Medicare

• Participation in the 340B (discounted) Drug Pricing Program

• Health Professional Shortage Area Designation and participation in National Health Service Corps

• Federal Tort Claims Act (FTCA) malpractice coverage

• Federal Loan Guarantee Program
What Is a Public Agency?

- The organization is a State or a political subdivision of a State with one or more sovereign powers
- The organization is an instrumentality of government, such as those exempt under Internal Revenue Code section 115
- The organization is a subdivision, municipality, or instrumentality of a U.S. affiliated sovereign State that is formally associated with the United States
- The organization is operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act or urban Indian organization under the Indian Health Care Improvement Act. Tribal Self-Determination legislation recognizes the primacy of the government-to-government relationship between the United States and sovereign Tribal nations. *(Note: the governing board requirements do not apply to these organizations.)*
Public Center Requirements

- Private, charitable, tax-exempt nonprofit organization must meet all program requirements (except where waivers permitted).

- Public center (a health center funded (or to be funded) through a grant to a public agency) may be structured in two different ways to meet the program requirements (direct or co-applicant arrangement).

  - **DIRECT:** Public agency meets all of the requirements of the section 330 program directly

  - **CO-APPLICANT ARRANGEMENT:** Public agency with co-applicant governing Board of Directors – collectively the two meet all section 330 requirements and are considered the public center
    - No exceptions from Board composition and selection requirements
    - Special considerations for exercising certain Board authorities
    - May share other responsibilities, provided that the co-applicant Board retains final and ultimate decision-making

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Co-Applicant Arrangement

“Health Center”/ “Public Center” = Both Public Agency and Co-Applicant Governing Board

Co-Applicant Governing Board
(Separate 501(c)(3) entity preferred)
1. Complies with all Section 330 composition & selection req.
2. Maintains key authorities and approvals regarding the 330 project
3. May employ management team/staff

HRSA/BPHC
Section 330 grant funds

Public Agency
1. Licensed provider (typically)
2. May establish general financial management and control systems
3. May establish personnel policies
4. May employ management team/staff, including CEO

Co-Applicant Agreement
HRSA strongly encourages the co-applicant board be formally incorporated to ensure maximum accountability for the patient majority board per the intent of the Health Center Program.

Public agencies and their co-applicants must execute, and present for BPHC review and approval, an agreement which describes the delegation of authority and defines each party’s role, responsibilities, and authorities.

- The co-applicant agreement is a separate document from the public center’s bylaws.
- The co-applicant agreement, bylaws, and/or articles of incorporation must assure that the health center co-applicant board retains its full authorities, responsibilities and functions as prescribed in legislation and/or regulation aside from those prescribed “general policies” that may be retained/reserved by the public center.
Co-Applicant Arrangement

• Consistent with legislative intent, the objective of the co-applicant arrangement is for the community-based governing board to set health center policy to the extent possible.

• Based on legal constraints that certain governmental functions may not be delegated to private entities, the co-applicant arrangement may allow the public agency to retain general fiscal and personnel policy making authority.

• The public agency and co-applicant may have collaborative roles in the exercise of other authorities, as long as these roles are clearly outlined in the co-applicant agreement and are consistent with the statements above.

• A pure “consensus” approach, without the subsequent required approval by the health center board, is not acceptable.
• A public center with an approved co-applicant arrangement does not need further justification for the public agency to retain final approval for the following:
  – General personnel policies and procedures, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal employment opportunity practices; and
  – General fiscal policies, including internal controls to ensure sound financial management procedures and purchasing policies and standards.

• Conflict of interest requirements: since together the public agency and the co-applicant board form the “health center,” no employee or immediate family member of an employee of the public agency or the co-applicant board, may serve as a member of the co-applicant board.
• Section 330(r)(2)(A) limits the total grant funding to public centers to no more than 5 percent of the appropriated funds for public agencies receiving funding under section 330(e) and 330(g).

• Currently, there are 99 public agency grantees:
  – 66 are State/County/local Health Departments
  – In FY 2009, received approximately $122 million in section 330 grant funding and almost $39 million in ARRA funds
• Health Center Program:
  – Discretionary grant program administered by HRSA.
  – Competitive application reviews with announced deadlines.
  – Project periods up to 5 years.

• FQHC Look-Alike Program:
  – Operated under an intra-agency agreement between HRSA and Centers for Medicare and Medicaid Services (CMS).
  – HRSA is responsible for assuring compliance with requirements under section 330 and making recommendations to CMS for designation.
  – CMS has final authority to designate FQHC Look-Alikes.
  – Non-competitive process - applications reviewed on a rolling basis in the order received (no set deadline).
Funding Opportunities

• FY 2010 Funding
  – No new competitive funding opportunities

• FY 2011 Funding
  – President’s budget request includes a total increase of $290 million:
    • Continue New Access Points and Increased Demand for Services funding initiated under ARRA
    • New funding opportunities for:
      – New Access Points
      – Behavioral Health Service Expansion
      – Planning Grants (if funds permit)
• Health Center Program funding opportunities are announced on:
  – HRSA web site: http://www.hrsa.gov/grants/default.htm

• FQHC Look-Alike Program:
  – application guidance is available at: http://bphc.hrsa.gov/policy/pin0906/
  – Applications are submitted directly to the HRSA/BPHC
QUESTIONS?
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